Personal Development Plan 2014 - 2017

[redacted]

Identified training (development) needs	Plan to address training needs	How will this help the Registrant in their job?	Achievement timescale
Improve IT/Computer Skills	Attend available training	Better client case recording	By June 2016
Presentation Skills	Apply for [redacted] Learning and Development training course	To help communication with colleagues and multi professional team	11 Feb 2015
Adult Safeguarding Policy CJSM	Attend Trust Workshop Complete e Learning	Improve knowledge with reference to role as Investigating Officer	On-going
Applying research to practice	Adult Safeguarding Programme SWK749 – Research Methods	Ensuring that practice with adult safeguarding is evidence based	Jan – March 2017
Improve knowledge and skills in other therapys	Attend Solution Focused Brief Therapy course	Widen knowledge and skill base to offer appropriate therapies to patients	27 Apr – 7 July
Empathy Skills	'reflective practice' group. Appropriate reading GAP Conference on Relationship based practice	It will maintain empathy and help with avoiding the pitfalls of functional and repetitive practice in a frequently emotional environment.	On-going

Signed (Registrant) [redacted]

Signed Line Manager/Mentor (if available) [redacted]

PRTL Submission Form

Full name: [redacted]

Employer name: [redacted]

Registration Number: [redacted]

Summary of Work Role (maximum 500 words)

I work as a social worker in an Oncology and Haematology social work team in a treatment and in-patient unit in a hospital, [redacted] The patients come from all 5 Trusts and occasionally from the Republic of Ireland as well. Service users are aged from 16 years upwards. My contact with patients, families and carers is hospital-based and I can have contact with patients across the disease trajectory, from recent diagnosis to terminal care. I work with patients who have specific cancers – upper gastro-intestinal cancers (including oesophageal/gastric/pancreatic/neuro-endocrine cancers) and penile and testicular cancers. Occasionally when covering duty I may be expected to work with patients with other cancers. Each cancer has specific characteristics and having worked in the [redacted] since it opened I have inevitably developed a level of specialist practice expertise and knowledge related to specific disease groups. For example, it is important to respect the different ways that people cope, to keep an open mind and to have an awareness about when people may wish to begin to talk about death and dying. The team offers a holistic person-centred approach and works collaboratively with other teams – medical, nursing, OT, Physiotherapists, Radiographers and palliative and clinical nurse specialists – in the hospital and social work and nurses in the community, as well as other voluntary and community agencies. The diagnosis of cancer can have a significant impact on patients and families and a fundamental part of our role is to provide emotional support to help them adjust and to maintain a sense of control in what can be for them a disconcerting context of fear and uncertainty.

Assessment and care planning is a key task at the early stage of contact with patients. At this point patients and carers may be going through significant transition and adjustment as they try to come to terms with diagnosis, treatment, disease recurrence or are reaching the terminal stage of the illness. Assessments may indicate the need for carer support services to facilitate discharge or for counselling support or financial help. Risks will be assessed and strengths identified. As a specialist team we can sometimes anticipate potential difficulties ahead for patients and be pro-active in our involvement. This may involve addressing support needs for children and making onward referrals to counselling agencies in the community. It is not uncommon to have intense emotional discussions with family members to help them adjust to the possibility that the illness may be terminal and to support them through anticipatory

grief. Families can appreciate a familiar face and continuity of contact as circumstances change. Another important role is to provide information to patients about support services available to them which they may need to avail of in the future. We have a gatekeeping role to supports and services such as charitable funds, volunteer drivers and volunteer helpers/befrienders.

I have completed training as an Investigating Officer and occasionally may be asked to carry out initial investigations when a referral of abuse has been received.

PRTL Submission

Personal Statement (page 1) **(Maximum 1500 Words):**

This should demonstrate that you have evaluated your learning and describe how you met standards 3 and 4. Additional space is provided on pages 20 and 21.

Total words: 1493 (excluding references)

In undertaking the course *SWK749: Enabling others through evidence-informed practice in adult safeguarding* I was able to consolidate a number of identified training objectives; these included improving IT skills, presentation skills, maintaining current knowledge on Adult Safeguarding and developing evidence based practice.

I presented research to prompt reflection and discussion on current assessment practice in the team and to consider whether more detailed assessment formats should be adopted in to better identify financial abuse of service users. Jarvis et al (2016;p.2) noted that while the NHS 'is a key partner with the local authority (LA) who lead in the statutory responsibilities in support of vulnerable individuals' there was concern 'about the engagement of the NHS in adult protection in general and the small number of NHS adult protection referrals. The NIASP Annual Report (2015) queried whether opportunities to intervene were being missed.

Kolb's (1984) experiential learning cycle and Vark's learning styles informed my approach to preparing the presentation. With its implication that 'all learning is re-learning' (Howarth and Morrison (1999), p.47) I needed to validate the existing experience and practice within the team and ensure that the subject/area of practice being focused on in the learning event built on this. The notion of 'dissonance' was useful. Kolb (1988) and Jarvis (1995) consider 'learning to be triggered by experience, either in terms of a problem to be solved, a situation that is unfamiliar, or a need that must be satisfied'(Haworth and Morrison (1999); pp. 50-51). Jarvis (1995) believed that learning occurred when previous experience and approaches appeared inadequate in relation to current demands resulting in a need to re-appraise.

I designed the presentation to emphasise the seeming ' dissonance' between prevalence rates of elder financial abuse and the low referral rate in hospital setting in order to prompt reflection, theorising and identification of further action that might need to be taken. I was aware that Government policy (DoH, 1998) and professional registration requirements (NISCC, 2005) place responsibilities on practitioners to develop their knowledge base and use 'current empirical evidence alongside professional judgement' (Taylor et al, 2015; HSCB, 2015)). Stevens et al (2005) identified 'a poor fit between available research findings and the needs of social work staff'. Therefore I tried to ensure that any material presented should be relevant for the team and have potential benefits for service users.

I considered research that related to prevalence rates of financial exploitation of older people in NI and ROI. I identified UK and international research to provide a wider context and to emphasize that it was a significant issue in older people's lives world-wide and that significant

resources were being directed towards it. I included research on the trial of a financial exploitation screening tool (Conrad et al, 2011) and (Phelan et al, 2014). The main piece of research that I focused on, a survey to establish the prevalence of financial abuse against older people in N Ireland, (COPNI, 2016), appeared to have validity and reliability. Given the recent policy and procedural changes in Adult Safeguarding I incorporated this into the presentation to remind participants of the changes in definitions regarding 'harm' and 'abuse' and to connect the research to this.

I learned that identifying relevant research is a complex and time-demanding activity. A significant amount of material is needed to form a one hour presentation. Identification involved searching data bases, peer-reviewed journals, bibliographic databases and using search engines. Time was needed to assess the research, using QAT assessment tools to establish relevance, reliability and validity. It was important to ensure that practical arrangements were considered and put in place. A key learning point was that being familiar with the material enabled me to answer questions and to acknowledge where there were gaps in the research.

Laing (1969) argues that critical reflection is essential to ensure that practitioners avoid becoming dogmatic in theory and repetitive in their practice. I measured the effectiveness of the presentation using Likert scale evaluation forms which provided immediate feedback on the participants' reactions to the event and whether some learning had been achieved. Furthermore they provided some information on potential future behaviour; several participants indicated that assessment practice in the team should be looked at further in light of the new information they had received.

Adult Safeguarding 'involves balancing the risk of harm with respecting adult's choices and preferred outcome for their own life's circumstances. (DHSSPS, 2015, p.5). Interventions should combine evidence based practice and reflection/analysis following the intervention to inform future practice. 'It is unethical to intervene in the lives of service users without seeking to gain an understanding of how an intervention might affect them and how an intervention has affected them and to share this understanding where appropriate, with service users' (Bell, 2005). Social workers have a responsibility to contribute to the improvement of professional practice (BASW, 2012). Any approach should be empowering, anti-oppressive and done in partnership.

Team members were notified that it was to be directly observed, to ensure that participation, which was voluntary, was by informed consent. Learning style questionnaires ensured respect for individual preferences. The presentation design enabled participant involvement in the session. Use of evaluation forms ensured that participants could identify any deficits and contribute to improvements in future presentations. Making available hand-outs of selected research and information regarding CPD enabled potential transfer of learning into practice (Horwath and Morrison, 1999).

I was aware that I was anxious prior to presenting. Being prepared is essential and this incudes doing appropriate research, being organised, planning, self-care and identifying and using support. A key learning point has been that you can engage with more confidence and be more open to service-user involvement and evaluation when you feel better informed, having looked at

relevant research. Completion of the IT course enabled me to prepare all the slides without secretarial support which was a huge step for me. The IT course has also helped me to improve my recording and to more readily assimilate new Trust recording systems.

Since this presentation I have been able to be involved in making a further presentation to new hospital social workers as part of their induction programme. I was able to draw on my previous learning and to undertake the task with less anxiety.

Other key areas in my PDP were: development of other therapies and maintenance of empathy skills. The Cancer Centre environment presents some unique characteristics and challenges because of the nature of the illness and its impact on service users. Patients present for curative, palliative and end of life care. While discharge planning remains a key area of social work involvement a further, probably more significant, area is that of relationship building to ensure the appropriate emotional support of service users and families as they face into uncertainty and potential loss and bereavement. Practitioner self–care is also important and the reflective space sessions are crucial as support to examine the emotional impact of the work.

The Solution-Focused Brief Therapy training provided an important opportunity to develop a new approach when working with service users. Utilising the knowledge and skills in work with a male patient provided new practice insights. He was attending for curative treatment as a day patient and had been referred because of low mood and anxiety. Rather than reading hospital case notes to 'tune in' I invited him to tell me something about a typical day, what he was interested in, what he was good at. Rather than focusing on problems and trying to fix them, as 'expert', the aim was to look at the patient's preferred future and their possible strengths and resources to achieve this. I explained the approach to him and after some bemusement he agreed to engage with it. For me this approach felt strange initially; I was worried that there was a risk that it might not be helpful for the service user (maleficence).'Listening with a constructive ear' involved listening for signs of strength, resilience, competence; anything that supported the idea that progress could be made. I asked him what he did well in his job and repeated 'What else? What else? in order to develop depth. I introduced the 'miracle question' asking how he would know if when he woke up the next day, his best hopes were achieved, how others would know and discussed the imagined day in detail. When I met with him for a second session he was very positive about the intervention because it had not focused on his cancer, was future focused and he had been able to follow through on some positive changes to his behaviour, taking his daughter to school and shopping with his wife rather than isolating himself at home. Using scale questions enabled him to see signs of progress. I had a sense of working in collaboration with and real engagement by the patient. I would hope to build on this approach in future personal development. I am also realistic that the approach would not suit everyone.

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PRTL Submission training consisted
Summary of PRTL Activities

Date	Duration (hours)	Brief description of activity
24.9.14	1.5	Reflective space session. Staff care counsellor facilitates discussion and reflection on social work/ counselling practice issues encountered by the group members.
11.11.14	1	Northern Ireland Regulations in respect of Care and Treatment. Awareness session providing information on eligibility of non-residents to have treatment in the National Health service.
12.11.14	3	Dying Matters Event - 'You only die once: An end of life discussion' QUB. The event encouraged communication about difficult situations through video, presentations and open discussion with attendees. Themes included 'what constitutes a good death', 'Breaking bad news', ' End of life patient care wishes', 'Autonomy and paternalism in end of life care'.
21.1.15	5	All Ireland Institute of Hospice and Palliative Care Social Worker Networking Event. This provided an overview of the AIIHPC and of palliative care provision in NI and ROI and also introduced us to research that Dr Audrey Roulston had completed in South America. The aim of the event was to share knowledge and to work toward a strategy that would enable better engagement by social workers of research in their practice.
22.1.15	2	Adult Safeguarding Policy Consultation Workshop. This looked at the change in definitions of adult abuse and implications for practice.
23.1.15	1	HRPTS. Employee self-service awareness session.
4.2.15	1.5	Reflective space session
10&11.2.15	12	Presentation/Facilitation Skills Programme. To facilitate knowledge and practice skills development to enable effective presentations. In service training.
17.6.15	1.5	Reflective space session
29.10.15	3	Workforce Planning Review – consultation process for the modernisation and workforce review for Older Peoples Social Work/Social Care Services. Part of an ongoing process to identify and consider opportunities for reconfiguration of services necessary to improve delivery.
10.11.15 Weekly (evenings)for	42.5	ICT Essential skills course; facilitated by Belfast Metropolitan College, Millfield Site. Skills development in Word, Excel, Internet research, working with images/shapes/word art, e-mail. Completion of a portfolio, including a newsletter, for the City and Guilds Start IT

17 weeks		(iTQ) Entry Level award. Course funded by NIPSA.
11.11.15	1.5	Reflective space session. These sessions are facilitated by a Staffcare counsellor on a roughly three monthly basis. It enables attendees to reflect on the emotional impact of engagement with service users and to discuss practice issues; there is usually a counselling element to the issue engaged. It can be a safe space to explore the personal impact of work with critically and terminally ill patients and their families.
20.1.16	1.5	Reflective space session.
11.2.16	1	Carers Awareness update. Information on services/resources for carers; session facilitated by Margaret McDonald, Carers Co-ordinator, Belfast HSC Trust.
27&28.4.16 6&7.7.16	24	Solution Focused Brief Therapy. Two module introduction to this approach facilitated by Evan George, a therapist based at BRIEF, London. The training consisted of lectures, videos, experiential role play, group reflection on practice issues to help build practice skills and a theory base. The approach is strengths-based, future focused and time-limited.
7.6.16	1.5	NISAT Training. Information provided to familiarise us with this assessment and recording system.
21.7.16	1	CJMS (Criminal Justice Secure Mail Network). E-learning module to provide information and practice in relation to the secure transfer of sensitive information. The system is used by PSNI, Probation Court Service, GAL service, Youth Justice Agency.
21.9.16	1.5	Reflective space session.
11.10.16	2	Team visit to Daisy Lodge, Newcastle – Northern Ireland Cancer Fund or Children. To familiarise ourselves with the resource and to network with staff. High quality residential accommodation for adults and children affected by cancer; services included complimentary therapies and group work (including outdoor) activities.
17.11.16	6	GAPS Day Conference on the Importance of Relationship-based Practice. Facilitated by Pamela Trevithick, Visiting Professor in Social Work, Buckinghamshire New University. This event looked at a Knowledge, skills and Values Practice Framework, a Lexicon of 80 skills and interventions and touched on the issue of how to humanise managerialism. It stressed the importance of the emotional life of human beings and the importance of the relationships we build in social work in order to aid effectiveness.

Jan-March 2017	300	Adult Safeguarding Programme 2016/2017 SWK 749: Enabling others through evidence-informed practice in adult safeguarding. An aim was to identify and explore issues in the context of the research evidence base; improve and develop and share best practice with others. I looked at local, national and international research on the financial abuse of older people and a model of assessment and then made a presentation to team members to facilitate reflection on the current assessment models that we use.
April 2017	20	The Iceberg by Marion Coutts, Atlantic Books, London (2014) This is a memoir by the wife of the art critic Tom Lubbock, who died from brain cancer in January 2011. Having worked for 'too many' years with cancer patients I am always concerned about potential burn-out or dilution of empathy. I read this to remind myself of patients/carers/ families lives away from the clinical settings. She coped by writing 'against annihilation' and described not only the intense emotional impact of being a carer for an ailing husband and very young son but also the day to day life of ordinary things such as going on outings/holidays, ensuring that her husband's writing life continued and maintaining their emotional world as a couple.
3.4.17	1	Training/Awareness session on RISOH (Electronic Care Record) recording system which is being introduced for medical and multi-disciplinary recording in hospitals across the region.

Total training and learning for period of registration

Hours: 435

Registrant Declaration

I confirm that I have undertaken the activities recorded on this form and that the details I have provided are accurate. I understand that failure to meet Post Registration Training and Learning Requirements, or the provision of false information in relation to meeting these requirements, may be considered by the Northern Ireland Social Care Council as misconduct.

Signed (Registrant): [redacted]

Date: 8th May 2017